MARYLAND HEALTH CARE COMMISSION

2006 PART II
JURISDICTION-SPECIFIC INFORMATION

Part II of the Home Health Agency Annual Report survey requests information on the services provided by your agency in each jurisdiction in which you operate. Please do not complete the survey for any agency you operate outside of the State of Maryland.

Please READ and CAREFULLY RECORD your responses legibly. PENCIL should NOT be used.

IMPORTANT!

ALL agencies,* whether or not Medicare-certified, *must provide information consistent with survey instructions.

NOTE: You are required to answer all questions. If you are unable to complete a specific question, you must attach a written explanation.

BEFORE YOU MAIL
CHECK LIST FOR PART II

(1) Did you complete the questions specific to the jurisdiction selected in Question 1 on page 3?

(2) Did you complete the responses on every page and attach a written explanation for those questions you were unable to complete?

(3) If your agency serves clients in more than one Maryland jurisdiction, did you complete a separate Part II survey for each jurisdiction?

(4) Did you complete a separate Part II survey for each branch and/or licensed Home Health Agency?

(5) Did you complete a separate Part II survey for each jurisdiction served during FY 2006 (refer to Question 16 of Part I)?

(6) Did an authorized agent of the reporting home health agency sign the statement of verification on page 2?

Survey Instrument – Part II
Fiscal Year 2006

VERIFICATION OF CLINICAL AND FINANCIAL INFORMATION

(Name of Agency - please print or type)

(Agency License #)

I hereby certify that I am an authorized agent of the reporting home health agency and can verify that the clinical and financial information submitted in this Home Health Agency Annual Report – Survey Instrument Part II, is true and correct, to the best of my knowledge, information, and belief.

_____ _____

Date Signature of Authorized Agency Representative

_____

Name and Title of Authorized Agency Representative
(please print or type)

HOME HEALTH AGENCY ANNUAL REPORT FOR FISCAL YEAR 2006
JURISDICTION-SPECIFIC INFORMATION

CURRENT AGENCY LICENSED NAME: _____

MEDICARE PROVIDER #: _____
(if applicable)

PLEASE BEGIN PART II

DO NOT USE PENCIL

IF YOUR AGENCY OPERATES IN MORE THAN ONE JURISDICTION YOU MUST COMPLETE A SEPARATE PART II FOR EACH ONE.

1. Using the following jurisdiction codes, **please circle the code beside the jurisdiction to which this FY 2006 service delivery data will apply**. If you have agencies operating in other jurisdictions, please complete a separate Part II for each one.

01	Allegany	09	Dorchester	17	Queen Anne's
02	Anne Arundel	10	Frederick	18	St. Mary's
03	Baltimore County	11	Garrett	19	Somerset
04	Calvert	12	Harford	20	Talbot
05	Caroline	13	Howard	21	Washington
06	Carroll	14	Kent	22	Wicomico
07	Cecil	15	Montgomery	23	Worcester
08	Charles	16	Prince George's	24	Baltimore City

ALL SUBSEQUENT QUESTIONS MUST BE ANSWERED WITH DATA SPECIFIC TO THE JURISDICTION CODE CIRCLED ABOVE.

ALL DATA MUST BE SPECIFIC TO THE JURISDICTION CODE CIRCLED IN QUESTION 1:

_____
Code #

2. Please breakdown the **total number of clients (based on an unduplicated count) served for FY 2006 according to primary payment source** and indicate the **number of visits financed by payer type**.

PAYER TYPE	CLIENTS	VISITS
MEDICARE (Traditional)		
Medicare+Choice		
MEDICAID (Traditional)		
Medicaid HealthChoice		
Other Government		
Private Insurers		
HMO		
Self Pay		
Other, Please specify		
Unknown*		
TOTAL		

*Unsure if client meets eligibility for reimbursement by certain payers, (i.e., Medicare or Medicaid pending)

3. Please classify and total the **number of clients (based on a duplicated count) served by your agency during FY 2006.**

LIVING SITUATION	# CLIENTS
TOTAL	
Living alone	
Living with Others	
Unknown	

ALL DATA MUST BE SPECIFIC TO THE JURISDICTION CODE CIRCLED IN QUESTION 1:

_____
Code #

4. Please report on the **charity clients*** served by your agency **during FY 2006.**

Number of Charity Clients	
Number of Charity Visits	
Total Dollar Value of Home Health Visits Provided to Charity Clients	**$**

*** See definition of "charity care" in Part I of this survey**

5. Please breakdown the **number of clients and number of visits** (**based on a duplicated count)** provided by your agency during FY 2006.

SERVICES	**# CLIENTS**		**# VISITS**	
	ADULT (>18)	**PEDIATRIC (<18)**	**ADULT (>18)**	**PEDIATRIC (<18)**
➢ Routine				
➢ IV Enteral TPN				
➢ Psychiatric				
➢ Early Maternal Discharge, Well Newborn				
➢ Antepartum Care, Fetal Monitoring				
SKILLED NURSING TOTAL				
➢ Home Health Aide				
➢ Physical Therapy				
➢ Occupational Therapy				
➢ Speech/Language Therapy				
➢ Medical Social Services				
➢ Other, please specify				
Subtotal				
TOTALS				

ALL DATA MUST BE SPECIFIC TO THE JURISDICTION CODE CIRCLED IN QUESTION 1:

_____
Code #

6. Please report the **number of visits provided by your agency per age group**. Total visits should equal the total number of visits recorded in Question 2, Part II.

AGE/YEARS	# VISITS
0-4	
5-14	
15-24	
25-44	
45-64	
65-74	
75-84	
85+	
Unknown	
TOTAL	

ALL DATA MUST BE SPECIFIC TO THE JURISDICTION CODE CIRCLED IN QUESTION 1:

_____
Code #

7. Please provide the **number of clients (based on an unduplicated count) by demographics** (i.e., age, race, and gender) served by your agency during FY 2006. The combination of total female/male population should equal the total number of clients in Question 2, Part II.

FEMALE POPULATION

AGE / YEARS	Hispanic or Latino	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or other Pacific Islander	White	Other	Total
0-4								
5-14								
15-24								
25-44								
45-64								
65-74								
75-84								
85+								
Unknown								
TOTAL								

MALE POPULATION

AGE / YEARS	Hispanic or Latino	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or other Pacific Islander	White	Other	Total
0-4								
5-14								
15-24								
25-44								
45-64								
65-74								
75-84								
85+								
Unknown								
TOTAL								

THANK YOU FOR COMPLETING PART II.

Please review the survey checklists before you mail.

BE SURE TO INCLUDE CLINICAL & FINANCIAL

VERIFICATIONS OF INFORMATION

FOR PARTS I AND II.

PLEASE RETURN SURVEY TO:

Catherine Victorine
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore MD 21215

www.mhcc.maryland.gov
410-764-3460
410-358-1236 (FAX)